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Robert A. Lowe

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Abstract

A number of national initiatives have focused attention on persistent racial and ethnic disparities in health and health care. The rising tide of improvements in health has not raised all boats; in some cases, the health gap between whites and minorities has widened. Although many social and economic forces contribute to this gap, inequitable access to health care also plays a part. This Issue Brief examines a common strategy that managed care organizations use to reduce emergency department visits—gatekeeping—and describes a study of the differential impact it may have on African Americans.

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Leonard Davis Institute of Health Economics

Robert A. Lowe, MD, MPH
LDI Senior Fellow,
Assistant Professor of Emergency
Medicine and Epidemiology
University of Pennsylvania

Does Managed Care Gatekeeping Affect African Americans' Access to Emergency Care?

Editor's note: A number of national initiatives have focused attention on persistent racial and ethnic disparities in health and health care. The rising tide of improvements in health has not raised all boats; in some cases, the health gap between whites and minorities has widened. Although many social and economic forces contribute to this gap, inequitable access to health care also plays a part. This Issue Brief examines a common strategy that managed care organizations use to reduce emergency department visits—gatekeeping—and describes a study of the differential impact it may have on African Americans.

Managed care organizations can require preauthorization of emergency department care

To reduce costs and improve care, managed care organizations have used various strategies to discourage visits to the emergency department (ED) for nonurgent care. One of the most common approaches is “gatekeeping”—requiring preauthorization for ED care as a condition to paying for that care.

- Typically, the gatekeeper is a primary care provider or managed care employee who must approve the ED visit for payment. The patient or ED staff usually calls the gatekeeper, describes the symptoms, and requests approval. If the visit is denied, the patient can choose to be seen anyway, but may be liable for the charges incurred.
- The clinical and economic rationale for gatekeeping has been questioned. Does it reduce costs? Does it erect barriers to needed care? Can a gatekeeper reliably assess the urgency of symptoms over the phone?
- In response to concerns about gatekeeping, Congress passed legislation in 1997 that mandated the “prudent-layperson standard” for Medicare and Medicaid enrollees. According to this standard, health plans must cover emergency services for these patients if the patient shows symptoms that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect to result in serious health impairment. This standard has since been extended to all enrollees in federal health benefits plans.
- More than 30 states have passed legislation requiring a prudent layperson standard for emergency care in all health plans. However, employees of large companies that “self-insure”—roughly 40% of all employees with commercial health insurance—are exempt from state regulation, and may still be subject to gatekeeping requirements.

Pilot study suggests that African Americans were more likely to be denied authorization for emergency care

The impetus for examining the link between race and ED gatekeeping came from a 1994 pilot study by Lowe and colleagues that identified how gatekeeping decisions were made. The study compared managed care patients in one Philadelphia ED who had been denied authorization (“cases”), with similar patients whose ED visits were approved (“controls”).

- Patients were enrolled in one of nine health plans. Each case was matched to controls enrolled in the same health plan. At the time, all plans required pre-authorization for ED care.
- Of the 195 patients with approved visits, 54 (28%) were white. Of the 49 patients whose visits were not approved, only 4 (8%) were white.
- This finding could have resulted if African American patients tended to go to EDs for less severe conditions. However, after statistically adjusting for the severity of their symptoms, African Americans were still 3.4 times more likely to be denied authorization than were whites.
- This disparity, by race, was unexpected and troubling. The authors launched a larger study to confirm these findings and identify other explanations.

Larger study investigates role of race, other factors in gatekeeping decisions

Lowe and colleagues evaluated the records of more than 15,000 visits to a Philadelphia emergency department from January 1995 to June 1996. They studied the records of white and African American patients enrolled in health plans that practiced gatekeeping. In addition to race, the study examined other factors that might influence gatekeeping decisions, such as the age and gender of the patient, severity of symptoms, type of health plan (commercial, Medicaid or mixed), and day and time of ED visit.

- Of the ED visits included in the study, most (73%) were by African Americans, and 67% were by Medicaid beneficiaries. Only 34% of visits occurred during usual office hours (Monday-Friday, 8 a.m. to 5 p.m.)
- All patients were initially evaluated by a nurse in the emergency department, and given a “triage score” that rated the severity of symptoms on a four-point scale. African Americans tended to have lower triage scores, indicating less severe conditions.
- 682 patients (4.4%) were denied authorization by their managed care gatekeepers. Of these denied visits, 22% were rated as more severe than the “minor” triage category by the ED nurse. This suggests a discrepancy between triage nurses and gatekeeper assessments of the severity of symptoms.

African Americans were 52% more likely than whites to be denied authorization

Through statistical analysis, the authors identified factors that predict gatekeeper denials. African American ethnicity, type of health plan, severity of symptoms, and day and time of ED visit were all significant predictors of ED denials.

- As expected, visits in “minor” triage category were 56 times more likely to be denied than visits categorized as “urgent”.
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- Patients were more likely to be denied on weekdays, especially during usual office hours, than on weekends.
 - After accounting for other significant factors, African Americans remained 52% more likely than whites to be denied authorization for care.

Findings indicate that gatekeeping is a barrier to emergency care for African Americans, although the reasons are unclear

Many of the factors that predict ED denials have plausible explanations. If gatekeeping works, it should deny authorization to patients with nonurgent problems. And gatekeepers might be more inclined to deny authorization for care in the ED on weekdays, when primary care providers have office hours. But the reasons are less clear for why, all other things being equal, Medicaid patients and African Americans were more likely to be denied authorization for ED care.

- The study findings do not suggest that gatekeepers, health plans, or ED staff are racist; in fact, most gatekeepers were part of large physician groups and probably did not know the race of the patient. It is possible that ED staff were more aggressive in appealing initial gatekeeping decisions for white patients than for African Americans, but no evidence, even anecdotal, supports this hypothesis.
- It is possible that African Americans and whites tended to go to different primary care providers, and that providers treating African Americans were more likely to deny authorization.
- Another possible explanation is that African Americans and Medicaid enrollees were less effective advocates for themselves in the gatekeeping process, which relies on somewhat subjective assessments of need for ED care.

POLICY IMPLICATIONS

For ED gatekeeping to be ethical, the process should not be influenced by nonmedical factors such as race. The study raises important questions about the equitable application of gatekeeping across racial groups and, therefore, the appropriateness of using gatekeeping to reduce use of the ED. To the extent that managed care gatekeeping of ED visits persists, more extensive study of the reasons for these inequities is warranted.

- This study provides support for the changes in managed care policies, regulations and legislation that occurred in Philadelphia after the data were collected. At least one Medicaid health plan dropped the requirement for preauthorization of ED visits even before the federal regulations required the change.
 - Partially in response to the findings of this study, a coalition of researchers, health plans, state and local regulators, and patient advocates has formed in Philadelphia to explore strategies to reduce the costs of ED care without incurring the risks of ED gatekeeping. One promising approach is to improve enrollees' access to primary care services, thereby reducing reliance on the ED for nonurgent care.
 - The prudent layperson standard for emergency services has been included in patients' rights bills now before Congress. These bills would extend the standard to all commercially insured people, and is one of the least controversial aspects of this legislation. However, passage remains blocked by a lack of consensus on other aspects of the bills, such as health plan liability.
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Janet Weiner, MPH, Associate Director for Health Policy, Editor
David A. Asch, MD, MBA, Executive Director

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3641 Locust Walk
Philadelphia, PA 19104-6218
215.898.5611
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